MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10073 10075

1 M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: St. Mary's County — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Leonardtown | c. LENGTH OF STAY IN 1b: ~~St. George's Island~~
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland | b. COUNTY: St. Mary's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. George's Island
   d. STREET ADDRESS: 18-1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Austin | Middle: Lawyer | Last: ADAMS
4. DATE OF DEATH: Month: July | Day: 6 | Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 29, 1876
9. AGE (In years last birthday): 91 yrs. | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Austin L. Adams
14. MOTHER'S MAIDEN NAME: Elizabeth Hatton
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 579-28-4528
17. INFORMANT: Paret K Adams — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
   PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Circulatory Collapse — INTERVAL BETWEEN ONSET AND DEATH: hrs
   Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
   DUE TO (b): Myocardial Infarction — hrs
   DUE TO (c): Arteriosclerosis — wks
   4201
   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fx. Rt. Hip
20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 11 — 6/25 1967
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) ST. GEO. ISLAND (County) ST. MARYS (State) Md

21. I certify that (I) (~~this hospital~~) attended the deceased from ____, 19 67, to 7/6, 1967, that (I) (we) last saw the deceased alive on 6/29 1967, and that death occurred at 11 AM from the causes and on the date stated above.

22a. SIGNATURE: James P. Jarboe M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 7/6/67
22c. PHYSICIAN'S NAME (Type): JAMES P. JARBOE M.D.
22d. ADDRESS: GREAT MILLS, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: JULY 8, 1967
23c. NAME OF CEMETERY OR CREMATORY: St Johns Church
23d. LOCATION (City, town or county) (State): Oxen Hill Md.

24. FUNERAL DIRECTOR: W. CLARKE MATTINGLEY — ADDRESS: LEONARDTOWN, MARYLAND
25a. REC'D BY REGISTRAR DATE: JUL 12 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4) 20M 1/65

1

FOR STATE HEALTH DEPT.

10074

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10076

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Compton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Compton
d. STREET ADDRESS: Compton
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

181

3. NAME OF DECEASED (Type or print): First CHARLES — Middle RUDOLPH — Last BOWES

4. DATE OF DEATH: Month July — Day 5 — Year 19 67

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: 12/19/1892 — 9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AMERICAN DIST. TELEGRAF(RETIRED)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOSEPH BOWES
14. MOTHER'S MAIDEN NAME: ALICE GREENWELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WWI
16. SOCIAL SECURITY NO.: 578 05 6223
17. INFORMANT: CHARLES R. BOWES JR. — Address: 6827 CUSTIS PKWY. FALLS CHURCH, VA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Heart Disease
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4221
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: O. H. Fisher M.D.
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Russell S. Fisher, M.D.
Address (Street, city, town, or county):
22. DATE SIGNED: July 5, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 7/8/67
23c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEMETERY
23d. LOCATION (City or Town) (County) (State): WASHINGTON, D.C.

24. FUNERAL DIRECTOR: John M. Welch
ADDRESS: JOHN M. WELCH - LEONARDTOWN, MD.
25a. REC'D BY REGISTRAR DATE: JUL 12 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10075

CERTIFICATE OF DEATH

10077

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Leonardtown
c. LENGTH OF STAY IN 1b: 5 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt. 2 Leonardtown
d. STREET ADDRESS: Rural Compton
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Ada — Middle: Cecelia — Last: Bussler
4. DATE OF DEATH: Month: July — Day: 29 — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Sept. 6, 1875
9. AGE (In years last birthday): 91 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Jeremiah Pope
14. MOTHER'S MAIDEN NAME: Mary Gibson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Madelene B. Mattingley — Address: Leonardtown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure
DUE TO (b): Senility — Cardio-Vascular
DUE TO (c):
Conditions, if ony, which gave rise to immediate couse (a), stating the underlying couse last.
4221
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/15, 19 66, to July 29, 19 67 that (I) (we) last saw the deceased alive on July 29 19 67, and that death occurred at 9 A.M., from causes and on the date stated above.

22a. SIGNATURE: Charles Greenwell M.D. — ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Charles Greenwell M. D.
22d. ADDRESS: Leonardtown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 8/1/67
23c. NAME OF CEMETERY OR CREMATORY: St. Francis Xavier
23d. LOCATION (City or Town) (County) (State): Compton, St. Mary's, Md.

24. FUNERAL DIRECTOR: W. Clarke Mattingley — ADDRESS: Leonardtown, Maryland
25a. REC'D BY REGISTRAR / DATE: AUG 7 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10076 10078

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4) 1SM 9/59

1. PLACE OF DEATH
a. COUNTY: ST. MARYS — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ST. MARYS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ST. MARYS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: VIOLET — Middle: ELEANOR — Last: BUTLER

4. DATE OF DEATH: Month: JULY — Day: 4 — Year: 19 67

5. SEX: FEMALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 9/21/1888

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER

10b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: DOMINIC BUTLER

14. MOTHER'S MAIDEN NAME: SUSIE BLACKSTONE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 216 24 5448

17. INFORMANT Address: MRS. HELEN HOLT - RT.1 BOX 17 MECHANICSVILLE,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Anemia	10 days.
DUE TO (b)	Hypertensive Vascular Disease	10 years
DUE TO (c)	Heart failure -	3 weeks

447x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month: Day: Year: 19 Hour a. m. p. m.:

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State):

21. **I certify** that (I) (this hospital) attended the deceased from Jan 1, 19 67 to July 4, 19 67 that (I) (we) last saw the deceased alive on July 4, 19 67, and that death occurred at 2 P M, from the causes and on the date stated above.

22a. SIGNATURE: Wm. H. Patrick M.D.

22b. DATE SIGNED: 7/5/67

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): WM. H. PATRICK M.D.

22d. ADDRESS: LEXINGTON PARK, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 7/6/67

23c. NAME OF CEMETERY OR CREMATORY: ST. ALOYSIUS CEM.

23d. LOCATION (City, town, or county) (State): LEONARDTOWN, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John M. Welch — JOHN M. WELCH - LEONARDTOWN, MD.

25a. REC'D BY REGISTRAR DATE: JUL 12 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10077

10079

1. **PLACE OF DEATH**
a. COUNTY: St. Mary's
MARYLAND
b. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town): Leonardtown,
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Mary's Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town): Lexington Park
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Leon Middle: Last: Chase

4. **DATE OF DEATH**: Month: July Day: 1, Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 14, 1918

9. AGE (In years last birthday): 48 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert B. Chase

14. MOTHER'S MAIDEN NAME: Agnes Mathews

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 220-16-4228

17. **INFORMANT**: Agnes M. Chase Address: Lexington Park, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis —
DUE TO
(b): Chronic Alcoholism
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 6 hours / 15 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from July 1, 1967 to July 1, 1967 that (I) (we) last saw the deceased alive on July 1, 1967, and that death occurred at 4 P M, from causes and on the date stated above.

22a. SIGNATURE: W H Patrick M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7-3-67

22c. PHYSICIAN'S NAME (Type): William H. Patrick M. D.

22d. ADDRESS: Lexington Park, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 3, 1967

23c. NAME OF CEMETERY OR CREMATORY: St. Peter Clavers

23d. LOCATION (City or Town) (County) (State): Ridge, St. Mary's, Md.

24. FUNERAL DIRECTOR ADDRESS: W. Clarke Mattingley Leonardtown, Md.

25a. REC'D BY REGISTRAR DATE: JUL 10 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jarboe

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10078

CERTIFICATE OF DEATH

10080

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ST. MARYS — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: S T. MARYS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
BRO. AMBROSE	DRISCOLL	C. F. X.	JULY	8	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	WHITE		7/7/1892	75 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
XAVERIAN BROTHER	RELIGIOUS	KENTUCKY	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
FRANCIS DRISCOLL	JULIA COLLINS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	215 56 7669	BRO. COLUMKILLE C.F.X. LEONARDTOWN, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 4201 Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: min
DUE TO
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Myocardial Infarction — min
DUE TO
(c): Coronary Artery Disease — yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. / Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
19					

21. **I certify** that (I) (~~was~~ hospital) attended the deceased from ..., 1964, to 7/8, 1967, that (I) (~~saw~~) last saw the deceased alive on 7/8/1967, and that death occurred at 4:45 A.M., from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
Jas P Jarboe			7/10/67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
JAS. P. JARBOE M.D.	GREAT MILLS, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
BURIAL	7/12/67	SACRED HEART NOVIATIATE	LEONARDTOWN, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John M. Welch	JOHN M. WELCH - LEONARDTOWN, MARYLAND	JUL 14 1967	J Charles Judge

VR A15 (4)
20M 5-63

1

10079

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10081

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Leonardtown
c. LENGTH OF STAY IN 1b: 2½ years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): St. Mary's County Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hollywood
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ella — Middle: A. — Last: Gatton

4. DATE OF DEATH: Month: July — Day: 7. — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 10, 1875

9. AGE (In years last birthday): 91 yrs.

IF UNDER 1 YEAR: Months: 11 Days: 27
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & Stote, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James King

14. MOTHER'S MAIDEN NAME: Margaret ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Joseph F. Joy Jr. — Address: same as # 2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO (b): Generalized arteriosclerosis — 10 years
DUE TO (c):
Conditions, if ony, which gove rise to immediate couse (a), stating the underlying cause lost.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 1965, to July 7, 1967, that (I) (~~we~~) last saw the deceased alive an 7/4 1967, and that death occurred at 7:30 A.M., from causes and an the date stated abave.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: July 9/67

22c. PHYSICIAN'S NAME (Type): P.J.Bean M. D.

22d. ADDRESS: Great Mills, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 9, 1967

23c. NAME OF CEMETERY OR CREMATORY: Nazarene Cemetery

23d. LOCATION (City or Town) (County) (State): Hollywood, St. Mary's, Md.

24. FUNERAL DIRECTOR: W. Clarke Mattingley — ADDRESS: Leonardtown, Maryland

25a. REC'D BY REGISTRAR DATE: JUL 12 1967

25b. REGISTRAR'S SIGNATURE: [signature] Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deloy is necessary, pleose execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funerol director. Page 4 should be forworded to the Chief Medical Exominer's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used os o buriol-transit permit. File pages 1 and 2 with the State Department of Health or its designoted agent, prior to buriol, cremation, or removol, and in any event within 24 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10080

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10082

1. PLACE OF DEATH
   a. COUNTY: ST. MARYS — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEXINGTON PARK
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): 06

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
   a. STATE: MARYLAND — b. COUNTY: ST. MARYS
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEXINGTON PARK
   d. STREET ADDRESS: 715 CHINLEE DR.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WILLIE — Middle: DARREN — Lost: GILES

4. DATE OF DEATH: Month: JULY — Doy: 22 — Year: 1967

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 16 FEB. 1962

9. AGE (In yeors lost birthdoy): 5 yrs.
   IF UNDER 1 YEAR: Months / Doys
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A

10b. KIND OF BUSINESS OR INDUSTRY: N/A

11. BIRTHPLACE (Stote or foreign country): FLORIDA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIE (NMN) GILES

14. MOTHER'S MAIDEN NAME: ELLA D. COOK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): NO

16. SOCIAL SECURITY NO.: N/A

17. INFORMANT — Address: WILLIE GILES SAME AS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): MULTIPLE INJURIES
   DUE TO
   Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse last.
   (b): BEING STRUCK BY A CAR
   DUE TO
   (c):
   INTERVAL BETWEEN ONSET AND DEATH: IMMEDIATE

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): Hit by auto

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m.: 22 JULY 1967

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☒

20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.): CHINLEE DR.

20f. (City or town) (County) (Stote): LEXINGTON PARK MARYLAND

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Wm D Boyd M.D.

EXAMINER'S NAME (Type): WM. D. BOYD M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): LEONARDTOWN, MD.

22. DATE SIGNED: 7/24/67

23a. BURIAL, CREMATION, REMOVAL (Specify): TRANSIT

23b. DATE THEREOF: 7/27/67

23c. NAME OF CEMETERY OR CREMATORY:

23d. LOCATION (City or Town) (County) (Stote): BROOKLYN, NEW YORK

24. FUNERAL DIRECTOR — ADDRESS: John M. Welch — JOHN M. WELCH - LEONARDTOWN, MD.

25a. REC'D BY REGISTRAR DATE: JUL 31 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10081

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10083

1. PLACE OF DEATH
   a. COUNTY: St. Mary's — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL Hollywood
   c. LENGTH OF STAY IN 1b: 6 mo.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Station Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: St. Mary's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lexington Park
   d. STREET ADDRESS: 107 Linden Lane
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Louis — Middle: Randolph — Last: Grant II

4. DATE OF DEATH: Month: July — Day: 6, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Cauc

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 21March1939

9. AGE (In years last birthday): 28 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U. S. NAVY

10b. KIND OF BUSINESS OR INDUSTRY: U. S. NAVY

11. BIRTHPLACE (State or foreign country): Mass.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Milton Grant

14. MOTHER'S MAIDEN NAME: Dorothy Radley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): 30June58-6July67.

16. SOCIAL SECURITY NO.: 029-28-4016

17. INFORMANT — Address: Official Military Records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Injuries multiple extreme.
DUE TO (b): Aircraft accident
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
860X

INTERVAL BETWEEN ONSET AND DEATH: Immediate.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Crash of helicopter

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 1015AM 6July 19 67

20d. INJURY OCCURRED While at work ☒ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Farm

20f. (City or town) (County) (State): Hollywood, St. Mary's, MD.

21. I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☒, Inquiry ☑, and in my opinion death resulted from: Natural Causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: [signature] M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): C. F. MAC CARTHY, LT MC USN

Address (Street, city, town, or county): NAS PAXRIVMD.

22. DATE SIGNED: 6July67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 7/11/67

23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL CEM.

23d. LOCATION (City or Town) (County) (State): ARLINGTON, VIRGINIA

24. FUNERAL DIRECTOR — ADDRESS: JOHN M. WELCH — LEONARDTOWN, MD.

25a. REC'D BY REGISTRAR — DATE: JUL 12 1967

25b. REGISTRAR'S SIGNATURE: [signature]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10082

CERTIFICATE OF DEATH

10084

1. PLACE OF DEATH
   a. COUNTY: ST. MARYS — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): ST. MARYS NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ST. MARYS
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - MECHANICSVILLE
   d. STREET ADDRESS: BOX 180 RT. 2
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
THOMAS	OGDEN	HARPER	JULY	1	1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
MALE	NEGRO	NEVER MARRIED [X]	8/7/1904	62 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A (BLIND)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: DANIEL HARPER
14. MOTHER'S MAIDEN NAME: LULA HARRIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: N/A
17. INFORMANT Address: MISS LULA HARPER - SAME AS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Intestinal obstruction - ileus. — INTERVAL BETWEEN ONSET AND DEATH: 3-4 days

5705

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e): Arteriosclerotic Cardiovascular, cerebral Thrombosis, Hemiplegia

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work [ ] Not While at work [ ]	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that (I) (this hospital) attended the deceased from May 1, 1967, to June 30, 1967, that (I) (we) last saw the deceased alive on 6-30-1967 and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE: J. Roy Guyther M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 7/3/67
22c. PHYSICIAN'S NAME (Type): J. ROY GUYTHER M.D.
22d. ADDRESS: MECHANICSVILLE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
BURIAL	7/4/67	ST. JOSEPHS CEM.	MORGANZA, MARYLAND

24. FUNERAL DIRECTOR ADDRESS: John M. Welch — JOHN M. WELCH - LEONARDTOWN, MD.
25a. REC'D BY REGISTRAR DATE: JUL 7 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10083

CERTIFICATE OF DEATH

10085

1. **PLACE OF DEATH**
a. COUNTY St. Marys County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown
c. LENGTH OF STAY IN 1b 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Marys Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE Md b. COUNTY St. MARYS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood Rural
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Gerard Middle: Elburn Last: Heyroad

4. DATE OF DEATH Month: July Day: 27 Year: 1967

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9/6/1888

9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Journalist

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (County & State, or foreign country) foreign Country

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gram Neg Septecemia - Bladder — INTERVAL BETWEEN ONSET AND DEATH 72 hrs.

605 X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Dey, Yeer 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May, 1960 to July, 1967, that (I) (we) last saw the deceased alive on 27 July 1967 and that death occured at 10 A.M., from the causes and on the date stated above.

22a. SIGNATURE J. Mossman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED 7/27/67

22c. PHYSICIAN'S NAME (Type) P. L. MOSSMAN

22d. ADDRESS Mechanicsville Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) ANATOMICAL

23b. DATE THEREOF 7-28-67

23c. NAME OF CEMETERY OR CREMATORY GEORGETOWN UNIV. MEDICAL SCHOOL

23d. LOCATION (City, town or county) (State) WASHINGTON, D.C.

24 FUNERAL DIRECTOR'S SIGNATURE James E. Woolf ADDRESS 2222 Wisc. Ave, N.W. Washington, D.C.

25a. REC'D BY REGISTRAR DATE AUG 3 1967

25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10084

10086

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: ST. MARY'S — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): RURAL PARK HALL
c. LENGTH OF STAY IN 1b: 3 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HILLXXXX BOARDING HOME

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ST. MARY'S
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): LEONARDTOWN
d. STREET ADDRESS: 181
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ANNIE — Middle: — Last: HOLLY

4. DATE OF DEATH: Month: JULY — Day: 9, — Year: 1967

5. SEX: FEMALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: ? ?

9. AGE (In Years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Butler

14. MOTHER'S MAIDEN NAME: Henny Milburn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service)

16. SOCIAL SECURITY NO.: 218-30-4057

17. INFORMANT Address: ALOYSIUS HOLLYWOOD, LEONARDTOWN, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Circulatory Collapse — INTERVAL BETWEEN ONSET AND DEATH: hrs
DUE TO (b): Cerebral Thrombosis — day
DUE TO (c): Generalized Arteriosclerosis — yrs
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from _____, 1966, to 7/9, 19 67, that (I) (~~was~~) last saw the deceased alive on 7/9/67, and that death occurred at _____ M, from causes and on the date stoted above.

22a. SIGNATURE: James P. Jarboe M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7/10/67

22c. PHYSICIAN'S NAME (Type): James P. Jarboe MD

22d. ADDRESS: Great Mills Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JULY 11, 1967

23c. NAME OF CEMETERY OR CREMATORY: Our Lady's Chapel

23d. LOCATION (City or Town) (County) (State): Medley's Neck Md.

24. FUNERAL DIRECTOR — ADDRESS: W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND

25a. REC'D BY REGISTRAR DATE: JUL 12 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10085

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10087

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: ST. MARYS — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PATUXENT RIVER
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): STATION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ST. MARYS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEXINGTON PARK
d. STREET ADDRESS: 410 YORKTOWN RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: NORVAL — Middle: ASHLEY — Last: HUGG

4. DATE OF DEATH: Month: JULY — Day: 27 — Year: 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/9/1909
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): METALSMITH
10b. KIND OF BUSINESS OR INDUSTRY: CIVIL SERVICE
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: GEORGE I HUGG
14. MOTHER'S MAIDEN NAME: CLARA LONG

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: 220 03 9071
17. INFORMANT — Address: MRS. INEZ HUGG - SAME AS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC ARREST
DUE TO
(b): CORINARY INSUFFICIENCY
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: Unknown / 6 mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐ 7/28/67

ACTUAL SIGNATURE: Wm D Boyd M.D. M.D.
EXAMINER'S NAME (Type): WM. D. BOYD M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): LEONARDTOWN, MD.
22. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 7/30/67
23c. NAME OF CEMETERY OR CREMATORY: TRINITY MEMORIAL GARDENS
23d. LOCATION (City or Town) (County) (State): WALDORF - MARYLAND

24. FUNERAL DIRECTOR — ADDRESS: John M. Welch — JOHN M. WELCH - LEONARDTOWN, MD.
25a. REC'D BY REGISTRAR DATE: JUL 31 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10086

CERTIFICATE OF DEATH

10088

1. PLACE OF DEATH
a. COUNTY: St. Mary's
MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Mechanicsville, Rural
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Rural Mechanicsville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: William Middle: Hayden Lost: Morgan
4. DATE OF DEATH: Month: July Doy: 7, Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Jan. 12, 1907
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & Stote, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Douglas Morgan
14. MOTHER'S MAIDEN NAME: Ida Russell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.: 218-36-4563
17. INFORMANT: Catherine H. Morgan Address: Mechanicsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Prob pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: Instantly
DUE TO
(b): Contusion, extremities, chest — 3 days
DUE TO
(c): Automobile accident
Conditions, if any, which gave rise to immediote couse (o), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o): Massive obesity - Wgt 350-400 lbs
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20o. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m.: 7-4 1967
20d. INJURY OCCURRED While at work [ ] Not While at work [X]
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.): Farm Road
20f. (City or town) (County) (State): Near Crayville Maryland

21. I certify that (I) (this hospital) attended the deceased from Oct, 1957, to Jun, 1967, that (I) (we) last saw the deceased alive on Jun 7 1967, and that death occurred at 1 M, from causes and on the date stated above.

22o. SIGNATURE: David Mossman M.D.
M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 7/8/67
22c. PHYSICIAN'S NAME (Type): David Mossman M.D.
22d. ADDRESS: Mechanicsville, Maryland

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 10, 1967
23c. NAME OF CEMETERY OR CREMATORY: St. Josephs Cemetery
23d. LOCATION (City or Town) (County) (State): Morganza, St. Mary's, Maryland

24. FUNERAL DIRECTOR: W. Clarke Mattingley ADDRESS: Leonardtown, Maryland
25o. REC'D BY REGISTRAR DATE: JUL 12 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10087

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10089

1. PLACE OF DEATH
   a. COUNTY: St. Mary's
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hollywood
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Station Hospital, NAS, Patuxent River, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: St. Mary's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
   d. STREET ADDRESS: 18
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): OLIVERA, Clifford Emil

4. DATE OF DEATH: July 6, 1967

5. SEX: Male

6. COLOR OR RACE: Cauc.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 15 NOV 35

9. AGE (In years last birthday): 31 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William L. Olivera

14. MOTHER'S MAIDEN NAME: Josie Stiefvater

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
    (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Nancy F. Olivera Address: Leonardtown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
    PART I. DEATH WAS CAUSED BY:
    IMMEDIATE CAUSE (a): Injuries, Multiple, Extreme — INTERVAL BETWEEN ONSET AND DEATH: Immediate
    DUE TO
    (b): Aircraft Accident
    DUE TO
    (c):
    Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

    PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Received fatal injuries in helicopter crash

20c. TIME OF INJURY Month, Day, Year: 10:15 Hour a.m. xxx July 6 1967

20d. INJURY OCCURRED While at work ☒ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Farm

20f. (City or town) (County) (State): Hollywood St. Mary's Md

21. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: C. F. MacCarthy M.D.

EXAMINER'S NAME (Type): C. F. MAC CARTHY, LT MC USNR

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): ASS

22. DATE SIGNED: 6JUL67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 7/8/67

23c. NAME OF CEMETERY OR CREMATORY: St. Andrews

23d. LOCATION (City or Town) (County) (State): Leonardtown St. Marys Md.

24. FUNERAL DIRECTOR: W. Clarke Mattingley ADDRESS: Leonardtown Md.

25a. REC'D BY REGISTRAR DATE: JUL 18 1967

25b. REGISTRAR'S SIGNATURE: Juliana Judge

Reno

4 1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10088

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10090

1. PLACE OF DEATH
a. COUNTY: St. Mary's County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b: 9 yrsrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
d. STREET ADDRESS: Rt. #1, Box 134 20650
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: John — Middle: Wilmer — Last: Thomas

4. DATE OF DEATH: Month: July — Day: 16, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Apr. 7, 1921

9. AGE (In years last birthday): 46 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (State or foreign country): Charles Co., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Francis Thomas

14. MOTHER'S MAIDEN NAME: Martha Hurd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 218-14-3717

17. INFORMANT: Wife — Address: Rt. #1, Box 134, Leonardtown, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shot gun wound. Rt. Groin - 981X — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Shot at Shot Range by assailant with Sawed off Shot gun.

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 1:30 7-16-67

20d. INJURY OCCURRED While at work [ ] Not While at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home -

20f. (City or town) Clements (County) St. Mary's (State) Maryland

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [X], Undetermined manner [ ]

ACTUAL SIGNATURE: Wm. Patrick M.D.

EXAMINER'S NAME (Type): W.H. Patrick M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X] Ass.

Address (Street, city, town, or county)

22. DATE SIGNED: 7-16-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 19, 1967

23c. NAME OF CEMETERY OR CREMATORY: Our Lady's Chapel

23d. LOCATION (City, town or county) (State): Leonardtown, St. Mary's, Md.

24. FUNERAL DIRECTOR — ADDRESS: Mattingley's Funeral Home Leonardtown, Md.

25a. REC'D BY REGISTRAR DATE: JUL 18 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10089

CERTIFICATE OF DEATH

10091

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: St. Mary's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Piney Point c. LENGTH OF STAY IN 1b: d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Piney Point d. STREET ADDRESS: e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Julius	Middle: Watkins	Last: Tolson	4. DATE OF DEATH	Month: July	Day: 20,	Year: 19 67		
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Aug. 5, 1899	9. AGE (In years last birthday): 67 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Beach Owner	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Warren Tolson		14. MOTHER'S MAIDEN NAME: Annie H. Simpson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):	16. SOCIAL SECURITY NO.: 577-07-3697A	17. INFORMANT: Rose G. Tolson	Address: Piney Point, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Ventricular Fibrillation	min.
DUE TO (b)	Myocardial Infarction	min.
DUE TO (c)	Coronary Artery Disease	yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 19__ to 7/20, 19 67 that (I) (we) last saw the deceased alive on 7/20/67, and that death occurred at 9:54 A.M., from causes and on the date stated above.

22a. SIGNATURE: J. P. Jarboe	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED: 7/2/67	
22c. PHYSICIAN'S NAME (Type): James P. Jarboe M. D.	22d. ADDRESS: Great Mills, Maryland		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: July 22, 1967	23c. NAME OF CEMETERY OR CREMATORY: St. George Catholic	23d. LOCATION (City or Town): Valley Lee,	(County) (State): St. Mary's, Md.
24. FUNERAL DIRECTOR: W. Clarke Mattingley	ADDRESS: Leonardtown, Maryland	25a. REC'D BY REGISTRAR DATE: JUL 25 1967	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

10090 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 10092

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: ST. MARY'S
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN,
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ST. MARY'S HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ST. MARY'S
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): VALLEY LEE
d. STREET ADDRESS: RURAL
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JOHN Middle ARTHUR Last VANDIKE JR.

4. DATE OF DEATH: Month JULY Day 2, Year 19 67

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: DEC. 21, 1908
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): NEW YORK
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN ARTHUR VANDIKE
14. MOTHER'S MAIDEN NAME: MARY CARRAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MARY R. VANDIKE Address: VALLEY LEE, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PROBABLE CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 2 HRS
DUE TO
(b): ATHEROSCLEROTIC C.V. DISEASE
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April, 1967, to June, 1967 that (I) (we) last saw the deceased alive on June, 1967 and that death occurred at 7:35 A.M., from causes and on the date stated above.

22a. SIGNATURE: J. Moorman
M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 7-3-67
22c. PHYSICIAN'S NAME (Type): J. ROY GUYTHER M. D.
22d. ADDRESS: MECHANICSVILLE, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 5, 1967
23c. NAME OF CEMETERY OR CREMATORY: St. George
23d. LOCATION (City or Town) (County) (State): Valley Lee, St Mary's Md

24. FUNERAL DIRECTOR: W. CLARKE MATTINGLEY ADDRESS: LEONARDTOWN, MARYLAND
25a. REC'D BY REGISTRAR DATE: JUL 10 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10091 Item #7 Filed 7/31/67 BM

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10093

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: ST. MARY'S — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): AVENUE
   c. LENGTH OF STAY IN 1b: 15 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: XXXXXXXXXX
   b. COUNTY: XXXXXXXXXX
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XXXXXXXXXXXXXXXX WASHINGTON, D. C.
   d. STREET ADDRESS: 400 INDEPENDENCE AVENUE N.E.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CARTER — Middle DAVID — Last WATERS

4. DATE OF DEATH: Month JULY — Day 18 — Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ unknown WIDOWED ☐ ? DIVORCED ☐

8. DATE OF BIRTH: 4-12-1916

9. AGE (In years last birthday): 51 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: MAXWELL WATERS

14. MOTHER'S MAIDEN NAME: BESSIE CARTER.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 227-18-9699

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Heart Disease — 10 years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): None

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W.H. Patrick M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): WM. H. PATRICK M.D.

Address (Street, city, town, or county):

22. DATE SIGNED: 7-19-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7-24-67

23c. NAME OF CEMETERY ~~OR CREMATORY~~: Church

23d. LOCATION (City, town or county) (State): Crewe, Va.

24. FUNERAL DIRECTOR: W. CLARKE MATTINGLEY

ADDRESS: LEONARDTOWN, MD.

25a. REC'D BY REGISTRAR DATE: JUL 25 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A1SME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10092

CERTIFICATE OF DEATH

10094

1. PLACE OF DEATH
a. COUNTY: ST. MARY'S
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): ST. MARY'S HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ST. MARY'S
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): RURAL MECHANICSVILLE, 12-1
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ETHEL Middle FLORINE Lost WILLIAMS
4. DATE OF DEATH: Month JULY Day 6, Year 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: APRIL 26, ~~1908~~ 1909
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months, Days
IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM WRIGHT
14. MOTHER'S MAIDEN NAME: ESTELLA M.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: J. STANLEY WILLIAMS Address: MECHANICSVILLE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis, massive — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Atherosclerotic cardiac disease — 5 yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse lost.
4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan, 19~~48~~, to July 6, 1967, that (I) (we) last saw the deceased alive on July 6 1967, and that death occurred at ___ M from causes and on the date stated above.

22a. SIGNATURE: J. Roy Guyther M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7-8-67
22c. PHYSICIAN'S NAME (Type): J. ROY GUYTHER M. D.
22d. ADDRESS: MECHANICSVILLE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: JULY 9, 1967
23c. NAME OF CEMETERY OR CREMATORY: TRINITY MEMORIAL GARDENS
23d. LOCATION (City or Town) (County) (State): WALDORF, CHARLES, MD.

24. FUNERAL DIRECTOR: W. CLARKE MATTINGLEY
ADDRESS: LEONARDTOWN, MARYLAND
25a. REC'D BY REGISTRAR DATE: JUL 12 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or ottending physicion.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the ottending physicion and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in ony event, within 72 hours after death.

VR A15 (4)
25M 1/67